

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                  |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>TN2002</b>                      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                             | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/07/2018</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WESTWOOD HEALTH CARE AND REHABILITATION C</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>524 WEST MAIN STREET<br/>DECATURVILLE, TN 38329</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| N 000  | Initial Comments<br><br>During the Fire Safety portion of the annual<br>licensure survey conducted on 05/7/18, no<br>deficienices were cited under the Tennessee<br>Department of Health, Board for Licensing health<br>Care Facilities, Chapter 1200-08-06, Standard for<br>Nursing Home. | N 000   |  |  |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE